

RETURN TO PLAY FORM COVID-19 MEDICAL CLEARANCE

For Physician Use

Per the University Interscholastic League, if an athlete has tested positive for COVID-19, it is strongly recommended he/she be cleared for activity by an approved health care professional (MD/DO/APRN/PAC). Individuals who have had COVID-19 are at risk of developing severe cardiac complications that can affect participation in sport. Evaluation and management by the primary care provider allows for the patient's past medical and cardiac history to be known.

Name: _____ DOB: _____ Date of Positive Test: _____

THIS RETURN TO PLAY IS BASED ON TODAY'S EVALUATION

Date of Evaluation: _____

Criteria to return (Please check below when applicable):

- Symptoms are resolved or nearly resolved, any remaining symptoms are not interfering with daily activities without medication
- No fever ($\geq 100.4F$) for minimum of 72 hours without fever reducing medication
- COVID-19 respiratory and cardiac symptoms (moderate/severe cough, shortness of breath, fatigue) have resolved
- Athlete was not hospitalized due to COVID-19 infection.

Cardiac screen negative for myocarditis/myocardial ischemia (All answers below must be no)

Chest pain/tightness with daily activities	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Unexplained Syncope/near syncope	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Unexplained/excessive dyspnea/fatigue w/ daily activities	YES <input type="checkbox"/>	NO <input type="checkbox"/>
New palpitations	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Heart murmur on exam	YES <input type="checkbox"/>	NO <input type="checkbox"/>

NOTE TO PHYSICIAN: If moderate disease OR any cardiac screening question is positive, further workup is indicated: 12 lead EKG with rhythm strip (at minimum,) echocardiogram, cardiology consult, chest x-ray, spirometry, chest CT, cardiac magnetic resonance (CMR)

- Athlete HAS satisfied the above criteria and IS cleared to return to activity
- Athlete HAS NOT satisfied the above criteria and IS NOT cleared to return to activity Medical Office Information

Additional Comments/ Recommendations:

Medical Office Information (Please Print/Stamp)

Evaluator's Name:

Office Phone:

Evaluator's Address:

Evaluator's Signature: